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CARING FOR OUR ELDERLY

An Inquiry into Working and Living Conditions in Alberta Nursing Homes

Submission to the Alberta Minister of Hospitals and Medical Care

by the Alberta Health Care Task Force
of the Christian Labour Association
of Canada

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PREFACE

The Christian Labour Association of Canada (CLAC) is an independent, all-Canadian trade union representing workers in health care, service, transportation, manufacturing, construction, and resource industries. As its name implies, the CLAC bases its mode of operation and its activities on the biblical principles of social justice and love for the neighbour. Christian social principles are basic concepts for just and charitable relationships among human beings, which are given expression in society by adherence to ethical and moral standards that reflect such social principles. These principles have bearing upon the dignity of human beings, their equality before God, and their responsibilities towards each other and to society as a whole.

All human beings bear the image of their Creator and must be treated with dignity, respect, and love. This is so for employees, employers, the elderly, and the disabled. Each person and group of persons has needs and responsibilities. We must take seriously our obligations to meet the needs of others. The government's task is to establish a framework in which these obligations can be fulfilled.

In this context CLAC established its Health Care Task Force in order to draw the attention of our legislators and the public to the need for reviewing the care given our elderly.

INTRODUCTION

The Christian Labour Association of Canada is a certified trade union that represents a sizeable number of employees in the health care sector. Currently, the CLAC holds the bargaining rights for the health care and service staff employees of some 60 health care institutions (nursing homes, rest homes, and hospitals) in Ontario and Alberta. CLAC represents approximately 300 members employed in nursing home facilities in Alberta. Over the years, our organization has increasingly become aware of the problems surrounding the care of our elderly and infirm. Like many other groups and individuals in the province, we are deeply concerned about -- and even alarmed at -- the way our society treats its senior members who live in institutions such as nursing homes and the circumstances under which the staff of these institutions must perform their work. Some time ago, our union executive decided to address the government of Alberta on these issues. However, it also decided that our submission should not be just another document drafted in someone's office, in isolation from what actually happens in our institutions for the elderly. For this reason, a task force of five persons was appointed to obtain information and evaluation from nursing home employees who are daily involved in caring for our elderly.

In order to achieve this goal, the Task Force convened 75 meetings in 42 locations across Alberta, and invited the employees of all 88 nursing homes in the province to attend. These employees were urged to bring along any others involved in health care institutions who could free themselves to be present. The meetings were held in October, November, and December of 1987, and in January and February of 1988.

The attendance at our meetings clearly showed the interest of nursing home employees; in fact, representation came from over 68 per cent of the nursing homes in Alberta. In addition we heard from representatives of active treatment hospitals, auxiliary hospitals, senior day care centres, lodges and home care programs. Our meetings were relaxed, informal, and from one to three hours in length. They focused on six crucial areas:

1. staffing levels
2. orientation and training programs for staff
3. quality care and privacy for residents
4. safety
5. funding levels
6. dispute resolution

Many related items were discussed and we will mention them as well in this submission.

We wish to stress that our meetings were not "gripe sessions." When the discussion began to drift into personal complaints, the chairman consistently steered participants back on course, that is, to tell the facts and give their evaluation of the actual care and working conditions in the institution concerned. For that reason we are confident that the picture painted by this submission is not a caricature sketched by people with personal axes to grind, but an accurate rendering of what is happening in our institutions for the elderly.

We submit this brief in the hope that you will give its contents every consideration. On the basis of our findings, we urge you to introduce changes in our health care system that will bring about acceptable working conditions for the staff and ensure that our elderly, often disabled citizens have a home where they can live their last years with dignity and respect. These changes include proper inspections, improved safety conditions, increased funding and staffing levels, and workable dispute resolution mechanisms to ensure just treatment for both residents and employees of these institutions.

Respectfully submitted
On behalf of the Task Force

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Edmonton, Alberta
April, 1988

STAFFING LEVELS

Throughout our sessions we asked the employees to give us a detailed account of the work they do on their shifts, the number of residents per employee, and the problems the employees encounter in doing their work.

Day Shift

All the nursing homes we surveyed began their day shift at seven o'clock in the morning. The night shift generally begins to wake residents shortly after 6:00 a.m. in order to get them ready for breakfast. In some institutions, employees dress residents as early as 5:00 a.m. and put them back in bed to wait for breakfast time.

A shift change occurs in the middle of this busy morning routine. This includes the report of the night shift to the day shift on changes in residents' conditions and the needs of residents that have yet to be met, as well as the general adjustment required to fit into the flow of work. Invariably, the work pace is hectic. Almost universally the complaint was heard that there is no time to give residents any personal attention. Matters discussed or promises made by employees to residents prior to the 7:00 a.m. shift change are often unknown to those coming on shift. There is absolutely no time for simple conversations about how the resident has slept, how he or she feels, or whether he or she has physical or medical needs.

In most homes the resident is roused from bed between 6:00 a.m. and 8:00 a.m. to prepare for the day. Obviously this is no small matter. Many of the residents need extensive preparation, such as washing, dressing, combing of their hair, shaving, helping them out of bed and into a wheelchair. A common frustration experienced by nursing aides is that residents must be assisted with these activities instead of allowing them to do it themselves as therapeutic activity lest they not be ready for breakfast time.

The rush that characterizes all institutions is unquestionably caused by low staffing levels. The Task Force heard the following illustration from employees at a home with 120 beds on two floors. Once readied for breakfast, employees on one floor help residents walk or push them in wheelchairs to the elevator. Another employee operates the elevator and brings residents to the next level, where other employees take them off the elevator and bring them to the dining room. Here the dietary staff serves the

residents food, and the nursing staff will feed them if they are incapable of doing so themselves. In the two hours between being awakened and being served breakfast, each resident has been helped by a minimum of five different staff members and has received a maximum of eight minutes care. The example we have used is from one of the better homes; some institutions have less time and less staff.

It is easy to lose sight of people when using statistics and numbers. Many residents have been incontinent during the night, others have different personal problems, needs or handicaps, and virtually all need extensive help. In most nursing homes more than half of the residents are considered "heavy care," meaning they require assistance with dressing, walking (or being placed in wheelchairs), and eating. Most nursing home residents who do not arrive on time for breakfast are restricted to a liquid diet until lunch-time.

In all the institutions we surveyed, the clock rules. A common complaint is that the clock runs the daily routine, especially at mealtime. Breakfast usually starts at 8:00 a.m. and the time allowed for breakfast is approximately 45 minutes. If one considers that in almost all institutions there are a substantial number of residents who require full assistance when eating, one should not be surprised to learn that frequently one nursing aide must simultaneously help at least two and sometimes three or even more residents. In several institutions it is impossible to feed a resident in a relaxed way. There is no time to ensure that the soup or other food is not too hot or too cold, so some residents refuse to eat or cannot keep up and consequently do not get adequate nutrition. Although some institutions allow breakfast at a later time for those who wish to sleep in, such situations are the exception rather than the rule. The rule is, if you're not on time you're out of luck. The dining room has to be cleared, floors cleaned,and facilities prepared for lunch. The residents are either taken back to bed, placed in the lounge, or seated in a chair in their room.

Immediately after breakfast begin the chores of making the beds and toiletting and bathing residents. Due to time pressures, residents (many not ambulatory and unable to help themselves) are expected to answer the call of nature when it fits the work schedule of the institution. Residents are often "assisted" in this rigid schedule by means of suppositories and in some instances enemas. One of the main duties during the morning shift is the bathing of a specific number of residents. Everywhere we heard that on average each resident receives one bath (either tub bath or shower) per week. Bed

baths or sponge baths are given daily. All staff members we interviewed indicated that one needs at least 20 minutes to properly bathe a resident, but such time is rarely available. In fact, most indicated that those residents who wish to sit and relax in the tub are not allowed to do so because that would take a way from the allotted time for other residents. We heard of only five homes where residents were allowed to spend extra time in the bathtub if they wished. These institutions have more tubs than is usual in nursing homes. It must be kept in mind that a substantial number of residents require extensive assistance, sometimes of two people, to lift them in and out of the tub since they are unable to help themselves due to physical or mental impairment.

In between these chores, the nursing aide on duty must hand out snacks, help the residents with further personal care, bring residents to activity programs and assist activity staff with exercise and other programs for residents. Often one third of the staff members are taken away from these morning duties to attend 45-minute in-service training programs or conferences, leaving the remaining employees to pick up the slack. Wedged in between these duties staff members take their 15-minute coffee break, but this is frequently shortened due to lack of time. In some cases, nursing aides told us, fellow employees give up their coffee breaks to sit and talk with or read letters to residents, for which there is no time otherwise.

By 12:00 noon all residents must be brought into the dining room for lunch. Again, the clock rules. In many institutions the main meal is served at noon, although in others it is served at 5:00 p.m. In any event, at both times hot food is made available, and the scenario repeats itself, that is, insufficient staff help the residents to prepare for lunch, assist or supervise them, and ensure that within 45 minutes all is done and finished.

The second half of the day shift's work is filled with putting the residents back to bed (many of them take a nap), dispensing snacks, and toiletting and bathing residents who are scheduled for it at that time. In addition, staff must answer call bells, do their paperwork, attend to the personal needs of the residents, and help out with activities for residents, such as bingos and other gatherings. Unfortunately there is seldom time for much personal attention. In one location nursing aides must spend five minutes a shift with depressed residents as part of their daily routine -- a clear admission that five minutes with a resident is an uncommon luxury.

Time and again we heard that the most oft-used phrase during all three shifts is, "Just a minute Mrs. _____, I'll be right back." This is the unfulfilled promise in every institution whose employees we heard from.

Afternoon Shift

In almost every institution the afternoon shift begins at 3:00 p.m. The first order of the day is to receive reports from the day shift about changes in residents' conditions and a general rundown of the day's difficulties and concerns. The afternoon shift begins by getting residents up from their afternoon nap and preparing them for dinner. While the workload at this stage of the day is not as heavy, staffing levels are on average 30 per cent lower than on the day shift. An institution employing nine nursing aides on the day shift will typically employ only six on the afternoon shift. The net result is that the workload does not diminish appreciably, if at all. On this shift, too, the staff and the residents are subject to the rule of the clock when it comes to toiletting and mealtimes. The afternoon shift has little time to talk with residents, let alone visit with them. From 3:00 p.m. until the supper hour most of the nursing aides' time is taken by changing and cleaning residents, rousing them from their nap, bringing them to activities, washing them and preparing them for supper. In many institutions the afternoon staff also must put away personal clothing returned from the laundry, and dust and clean the residents' furniture.

At supper time (usually at 5:00 p.m.), staff must assist the residents in travelling to the dining room, help them eat, and return them to their rooms. A common frustration expressed is that during mealtimes the institutions are shamefully understaffed. Some institutions assist their staff by hiring students to help during the dinner hour. We were told that at one institution, 20 residents in a separate dining area receive only 15 minutes supervision during each 45-minute mealtime.

After supper the schedule includes such duties as straightening out beds, toiletting, distributing snacks, tidying residents' rooms, taking care of their personal belongings, and preparing them for bed. In several institutions nursing staff must also assist housekeeping employees in cleaning the dining room. Most residents are in bed by 9:30 p.m., after which nursing aides must do their paperwork and make regular rounds.

Night Shift

The night shift, which in most institutions comes on duty at 11:00 p.m., is almost always staffed 30 per cent lower than the afternoon shift. This means that there is about one staff member for every 25 residents between 11:00 p.m. and 7:00 a.m. Although most of the residents are asleep during this shift, making rounds and doing paperwork takes a considerable amount of available time. Nursing aides must answer call bells from residents in need, and in many institutions, must sanitize bedpans and clean wheelchairs and nursing stations. In several rural institutions, employees also must answer emergency phone calls from seniors living by themselves. The last of the night shift duties includes waking the residents to begin readying them for breakfast.

A very disturbing element of low staffing levels on the night shift is the insufficient number of staff in the building when emergencies arise, especially in cases of fire. Given that in most nursing homes about 50 per cent of the residents are unable to get out of bed or walk by themselves, one need not have a vivid imagination to see the potential for catastrophe.

We recommend:

1. that every nursing home be required to provide a minimum of 2.75 hours nursing and personal care each day to each heavy-care (auxiliary) resident;

2. that every nursing home be required to provide a minimum of 2.0 hours nursing and personal care each day to each light-care resident.

INSPECTIONS

We spent some time at each meeting discussing the effectiveness of the government inspection system. The general pattern, we heard, is that inspectors arrive at the home, are met by the administrator and are given a tour of the facility. The inspector seems to pay much attention to the cleanliness and the general appearance of the facility, but makes little effort to talk to employees. Problems or complaints from the inspector are passed on by the administrator to the staff. At no time is the staff given the opportunity to talk to the inspector on an individual basis. In one isolated case an inspector did speak to employees individually and "in confidence." Two weeks later management knew what was said and who had said it.

The most disturbing factor in the inspection process is that inspectors appear to have little interest in hearing the staff's point of view. Management also seems to shield inspectors from the employees, and employees from inspectors by staying with the inspector at all times during the inspection tour. The inspectors judge the home on the basis of its charts and its physical appearance. Yet these two elements tell only a small part of the story. Both residents and employees should be consulted on the type of care received and given.

Employees told us that inspections should be conducted on a surprise basis, at any hour of the day or night, and in the absence of management staff. In addition, inspectors should randomly select residents and employees to whom they speak in total privacy. The resident ombudsman, a position this submission recommends be instituted in each nursing home (see "Residents' Councils"), should be consulted by the government inspector as well.

We recommend:

3. that inspection of nursing homes be conducted unannounced and that inspectors interview employees from all shifts and from all departments, as well as residents, in confidence and in the absence of management.

ORIENTATION & TRAINING

All nursing homes hire most of their nursing aides "off the street," which means they have little or no training and must learn on the job. Most institutions train new employees by having them read manuals for one day and work alongside an experienced aide for two days. This adds to the existing staff's already heavy workload and results in less than adequate orientation, so that trainees often learn poor care habits from their fellow employees. The maximum training any institution gave was five days while the minimum was one day. After this small amount of training, new employees carry a full workload and are expected to be fully knowledgeable about how to care for the residents, some of whom are fully bedridden, partially paralyzed, or suffering from such crippling ailments as Alzheimer's disease. Managements in almost all nursing homes defend themselves with the claim that there are no funds available for training. We find this an abominable situation for new employees as well as for the residents. The latter risks harm from being treated by untrained personnel; the former is in danger of injuring herself because of insufficient skills in handling disabled residents.

Some nursing homes have made it compulsory for nursing staff to take a Personal Care Aide (PCA) program. We welcome such requirements, provided employees are given the required time to take the course and provided existing employees with adequate on-the-job training experience are "grandfathered" into the program. At the same time it must be pointed out that this does not alleviate the problem faced by new trainees. The personal care aide program is only made available to employees who have worked at nursing homes for a period of time, meaning that the inexperienced nursing aide continues to carry a full load after a totally inadequate two-day training period.

In-Service Training

Throughout the province employees told us that their nursing homes regularly conduct in-service training programs for employees. Most medium- and large-sized homes employ a training coordinator to teach upgrading programs for employees during working hours. Most programs are run several times to enable employees from each shift to attend. However, in many cases employees are required to report for in-service programs on their day off, without pay.

It became obvious during our interviews that these programs would be much more effective if there were adequate staffing in nursing homes. In most cases the in-service programs take nursing aides off the floor, further reducing the already minimal care. Because of time limitations, the programs are conducted in a hurried manner and so lose some of their effectiveness.

In rural communities and for part-time employees the in-service programs are even less effective. Due to longer distances in rural communities, employees who are on their days off find it difficult to come all the way to work to make use of the programs, while many part-timers are not at the home often enough to make full use of the programs. The Task Force heard of a few homes where in-service sessions are now videotaped to allow night staff and part-time employees to view the session at a later time, during their scheduled working hours.

We recommend:

4. that orientation and training of new staff in nursing homes be done by competent supervisory personnel;

5. that each nursing home be required to give a minimum of ten days orientation and training for new inexperienced staff before they are allowed to work alone and five days for new staff with a PCA Certificate;

6. that the Government require nursing aides to obtain a Personal Care Aide certificate, provided that existing employees receive enough leave time to follow the required courses, and provided that "grandfather" provisions are made available to those with three or more years experience;

7. that funds be set aside to replace staff attending in-service sessions, to pay in-service program participants who must attend on their days off, and to improve the quality and effectiveness of the in-service programs themselves.

ACTIVITY PROGRAMS

Activity coordinators, generally with the help of volunteers from the families of the residents and the community, can provide meaningful activities for the residents to keep them alert, physically active and socially involved.

In 1986 the Alberta Government introduced a new program designed to encourage nursing homes to hire occupational therapists and physiotherapists. Funding was made available to all nursing homes on the condition that they have therapists on staff. Most employees applauded this development. Problems arose from the fact that there are insufficient physio- and occupational therapists available. Nursing homes are competing with other institutions for their services. Consequently, a therapist often will set up a program, only to leave suddenly for work elsewhere. In such cases, program funding is cut off the day the therapist leaves and untrained nursing aides are left to carry on the program, further cutting into personal care time.

Aside from the government-sponsored therapy programs, most homes have their own activity programs. However, these programs are frequently not integrated for the residents and, although implemented with good intentions, are ineffective. The example we heard of an 85-year-old resident throwing a sponge ball but receiving no help with dressing activities is apparently quite typical. There is a lack of helpful, down-to-earth programs to enable residents to cope with daily living.

We recommend:

8. that activity programs for heavy-care residents be implemented on an individualized (one-on-one) basis.

REGIMENTATION

In a rapidly aging society it is ironic that the rights of our seniors are ignored while we accord an inordinate amount of publicity to the rights of others. Our seniors in long-term care institutions are being treated like army recruits and in some cases like prisoners.

Although the situation is improving, regimentation continues to be standard practice in virtually all nursing homes. People who have reached the age of 70, 80 or older are forced to live by the clock, are told when to get up, when to go to bed, when to toilet, and when to bathe, and thereby are deprived of choosing their own lifestyle. There is no time for helping out with such common problems as constipation. In a substantial number of homes the quick and ready remedies are suppositories and enemas. Such remedies are not primarily used to assist the residents, but rather to speed up the process so that the workload can be completed within the allotted hours. The Task Force heard that in a limited number of institutions encouraging progress has been made in dealing with this problem through the use of natural fibres and exercise programs. As our seniors grow older, their physical and mental faculties slow down; yet they are seldom allowed to sleep in, take a bath when they would like, eat when they are ready, or stay up late when they so desire. They are treated like a herd while employees rush about unable to give the individual care they would like because of heavy workloads and serious time limitations.

Our nursing homes resemble assembly plants rather than "caring" institutions. There are many institutions in our province where the term "seniors factory" would be more applicable than the name nursing home. Our rhetoric about the dignity of the aged is all too often a hollow masquerade behind which we hide our apathy.

We recommend:

9. that residents of nursing homes, when capable, be allowed to determine their own hours of getting up and going to bed, within reasonable time frames.

PRIVACY

An often voiced concern we heard was residents' lack of privacy--the result of living in a ward of four beds or semi-private rooms with a shared bathroom between two rooms. Frequently one room is occupied by women and another by men, creating the embarrassing and unacceptable situation of someone from the other room opening the door while a resident is using the toilet.

Another problem stems from the fact that nursing home rooms are built like hospital rooms with one bed next to the window and the other next to it, closer to the hall. A resident occupying a bed beside the window can often not draw the curtain between the two beds because it cuts off daylight from the next bed. This creates constant pressure to keep the curtain open and thereby eliminates the possibility of controlling one's own privacy. It must be kept in mind that many of the elderly in our nursing homes are no longer able to help themselves. It is therefore only natural that when residents are resting on top of their beds during the course of a day they should not have to be concerned about their attire. Unfortunately they are generally in full view of their roommate and of visitors and staff who constantly walk by the open door of the room. Drawing the curtain around the bed brings protests from the other resident(s) sharing the room (because it blocks their view to the outside or to the hallway door) and from the staff (because it is difficult to "keep an eye" on the resident they cannot see).

Toiletting residents who cannot help themselves is another problem. We heard of cases where residents are put on the toilet with the door open so the nursing aide can keep an eye on him/her while performing other duties.

An added concern is that many institutions lack a separate area for residents who are so disabled that they cannot eat in a socially acceptable way. Mixing of all residents during meals creates unappetizing situations for everyone and degrading embarrassment for those who are alert but physically unable to help themselves.

We believe that the design of nursing homes should and could be changed in such a way that each bed faces the outside window, thereby allowing for the possibility of separating the beds with a curtain to give maximum privacy without cutting either bed off from access to the outside window or the inside door to the hallway. There should also be a bathroom in each room, accessible to wheelchair residents.

We recommend:

10. that every newly constructed nursing home shall, within a feasible time span, eliminate all wards accommodating more than two residents;

11. that every nursing home shall, within a reasonable time span, provide a separate washroom for each room, accessible by wheelchair.

SAFETY

Throughout the province we found that safety procedures and fire drills were given very high priority. Each institution has well-worked-out contingency plans and gives sufficient weight to their importance by familiarizing all employees with emergency procedures.

Fire drills are conducted frequently in almost all nursing homes. Often these are held without warning to test the reaction time of the staff and their familiarity with procedures.

However, no matter how many hours are spent on training, the stark reality is that from 11:00 p.m. to 7:00 a.m. daily, each nursing home in the province is a potential death trap. With an average of one staff member per 25 residents in almost all nursing homes, it is exceedingly difficult if not impossible to safely evacuate the premises in case of fire. One must remember that up to 50 per cent of residents cannot physically help themselves or cannot mentally comprehend and appropriately respond to a fire hazard.

The potential risk is not due to faulty procedures, facilities, or lack of training, but solely to understaffing. Understaffing is the direct result of insufficient government funding and inadequate minimum staffing requirements. It also reflects the preoccupation of not a few private nursing homes with making money for their owners and shareholders, and the fact that care provision for the elderly as well as wages and working conditions of staff members are secondary considerations. These problems would be eliminated if adequate staffing levels were implemented (see our recommendations [1] and [2]).

MEDICATION

Although the Task Force did not direct its inquiry at the medical end of resident care, disturbing evidence about this issue repeatedly surfaced during our hearings and warrants our mention.

In a significant number of homes, mostly in small rural centres, untrained and unqualified employees are being used tc change dressings, take vital signs such as blood pressure and pulse rate, and to hand out medications. In most of these instances, medications have been prepared by a qualified registered nurse, but are given to the resident by non-registered nursing aides in the course of their duties. Nursing aides are allowed to refuse to distribute medications. However, in most situations the psychological pressure created by the fact that the residents would not get their medication if the nursing aide refused is strong enough to have her comply with the institution's request. That the procedure has potential dangers is clear to all. That it takes unfair emotional advantage of nursing aides should be obvious.

An equally disturbing trend is the fact that very active residents in some nursing homes are being subdued through medication, sometimes without the express consent of the attending physician. In an environment where staff is constantly coping with time limitations and any single incident can throw off the entire day's schedule, the temptation to pacify energetic residents becomes all too strong. For a significant number of homes, the creation of elderly "zombies" who no longer have a personality of their own seems to be a small price to pay to ensure the work gets done. Who would want to place his ailing parent(s) in such an environment?

FOOD

It was encouraging to hear that in most homes the food is tastily prepared and there is sufficient quantity for those who can eat fast and meet the deadlines.

A major problem, already mentioned under "Staffing," is that you eat at set times or forgo your meal altogether. This creates assembly line regimentation and can best be illustrated by what we heard from the staff of one home. Because of its dining room size the residents eat in two shifts. In this particular home breakfast is served at 8 a.m. and has to be completed by 8:25 a.m., when the residents are ushered out. The dining room is then quickly cleaned, the tables reset, and at 8:30 sharp the second shift eats breakfast. Although they are under less time pressure, the meal needs to be concluded by 9:15 a.m. It is fair to say that many of us would not be able to sit down, eat our meal, and leave the table all within a span of 25 minutes. That this is impossible for seniors is something everyone should be able to understand. This scenario repeats itself for lunch and supper day after day. In such circumstances meals are not an occasion for enjoyment but an event filled with frustration, indigestion and a lack of dignity and satisfaction.

The almost universal complaint is that there is no choice. "You eat what is prepared for the meal or you don't eat." The Task Force heard that because eggs are an inexpensive source of protein, residents often are served eggs twice a day -- boiled, fried, scrambled or in omelettes. Many of the nursing homes also paid little attention to the appearance and attractiveness of the food served. Although it is difficult to serve a wide range of menu choices in an institutional setting, it seems to us that some variety is possible; indeed, a number of nursing homes are providing that service. Food can be served attractively if sufficient time is allotted and available.

We recommend:

12. that every nursing home be required to make dining room service available for its residents, and that residents be allowed to select their meals from a variety of foods at a time of their own choosing within normally set hours.

RESIDENTS' COUNCILS

The formation of residents' councils is mandatory in the province of Alberta. Concerns were expressed about the operation of such councils and we discovered that in the majority of cases the council is run by the activity coordinator or the administrator of the institution. The result is that residents' councils have become largely ineffective. Currently they decide matters such as bus outings, family days, and special residents' parties. They also approve the spending of funds designated for the residents' councils. This is money raised by the residents in the nursing home specifically for the residents' council. There is no funding available for this purpose from either the government or the institution.

The participation of management in the councils, we heard, usually reflects a sincere desire to assist the residents in such matters as keeping minutes and making recommendations. Nevertheless, we found that management's presence often hinders open discussion about the problems residents face in nursing homes.

We suggest that a well-informed outside person could restore the effectiveness of the residents' council by serving as the liaison between it and the management of the nursing home. This person would serve as an ombudsman and attend all residents' council meetings in place of management personnel. Such a person should be familiar with nursing homes and their operations and should have the confidence of the residents. This could be a local pastor or social worker. Minutes of these meetings should be posted so that all residents, employees and management personnel are aware of residents' concerns.

We recommend:

13. that every nursing home have on its residents' council an informed individual from the community to serve as a liaison between nursing home management and the residents, and that management personnel not serve on residents' councils but be available as resource persons when so requested.

STAFF MORALE

The overriding theme throughout our hearings was that employees do not have sufficient time to give proper, all-encompassing care to the residents. The inability to sit down with a resident who is visibly distressed places a burden of guilt on the employee responsible for caring for that resident. Having to hurry residents to and from their meals, refusing them the opportunity to relax in the bathtub, and forcing them out of bed causes staff burnout or a hardening of the staff's feelings.

Employees also risk abuse by residents who they must nevertheless care for. Respondents from every location knew of employees who had been physically attacked (hit, scratched, had their hair pulled) or verbally abused by residents. Employees who belong to a visible minority group often have to put up with racist remarks. In one home a nursing aide had her nose broken; in another a nursing aide was kicked in the chest so severely that she developed an infection in her breast which eventually forced her to stop working. Much of this abuse is a result of aggression or irritation created when nursing aides rush residents in order to meet work schedules.

In all of the day-to-day experiences, difficulties and challenges, nursing home employees receive little support, and as a result staff morale is often low and burnout high.

COMMUNITY INVOLVEMENT

Most nursing home managements actively encourage community and family involvement in the operation of their homes. Church communities are consistently in the foreground of providing volunteer services to nursing homes. In almost every community, a few individuals are willing to volunteer substantial amounts of time to help care for residents. Family involvement ranges from excellent to poor. Every nursing home can tell of those who consistently visit and help care for their resident family member. Unfortunately, many residents are all but abandoned by their families. During an emergency in one home, residents' families were requested to take their family member home for a few days; more than ten per cent flatly refused to become involved or take any responsibility.

Families of residents need to be involved to a greater extent than they currently are. They, more than anyone else, are able to provide the emotional support every human being needs and deserves. This can take the form of daily visits, reading to residents, taking them out for part of a day if they are physically able, and making them continue to feel part of a larger family unit. One of the most important elements missing in the interaction between nursing home residents and families is children. Consistently we were told that when children enter the nursing home, residents sit up and take notice, including those residents who are no longer able to communicate. Communities, too, have a great deal to offer by volunteering their services to help with activities, bingos, variety programs and outings. They can also volunteer to perform personal services, such as repair of clothing. Most importantly, they can visit residents on a one-to-one basis, especially those who have been abandoned by their own kin.

The public perception of nursing homes is largely negative. Much of this is due to misinformation and sensationalized media reports, such as that of a wandering resident who walks out into the cold and is found frozen to death. Seldom does the media report on positive aspects of life in our nursing homes or on the local community's involvement. We believe that the media needs to take some responsibility for creating an awareness of the seniors' facilities in their community and for encouraging family and community involvement.

RECORD KEEPING

A common complaint we heard across the province was the inordinate amount of time spent on record keeping. Almost everyone who appeared at the Task Force hearings expressed concern that registered nurses, who are supposed to provide medical care to residents, have become paper pushers. They are busy filling in charts, reports, and medication sheets while untrained nursing aides are being told to change dressings, take blood pressures, and make other routine medical checks.

This has serious repercussions for the residents and the staff. First, the resident is being deprived of the trained eye able to diagnose problems while taking vital signs such as blood pressure, heart rate, etc. Second, nursing aides are once again placed in the position of having to do work that should be done by others, taking away from their ability to give the kind of physical care that is already limited because of insufficient staffing.

While we recognize that complete records are needed to maintain standards, record keeping should not be an end in itself. Double, triple, and quadruple charting takes away time from the hands-on care residents need and crave.

FUNDING

Originally, auxiliary hospitals were to provide long-term care for those persons in need of complete medical and physical care, while nursing homes would provide care for seniors who were still ambulatory. The actual situation today is very different. Nursing homes and auxiliary hospitals are now almost indistinguishable with respect to the level of care provided. The government tacitly admitted this when it recently introduced extra funding for those nursing homes with heavy-care (auxiliary) residents in excess of 20 per cent of their total resident population. At the same time, it should be recognized that most auxiliary hospitals now have quite a few ambulatory residents. It is clear that current admissions policies for nursing homes and auxiliary hospitals have resulted in inadequate care and misallocation of tax payers money, and therefore have failed.

All employees interviewed by the Task Force stated that the percentage of heavy-care (auxiliary) residents in nursing homes continues to increase almost daily. We think this trend is due to several causes, among them the tendency of active treatment hospitals, under their own budget constraints, to send senior, heavy-care (auxiliary) patients to nursing homes with available beds instead of to auxiliary hospitals with lengthy waiting lists. This reality obviously renders the amount of government funding to nursing homes inadequate, which is reflected in the too-low staffing levels. Less available staff time for residents means a more rapid mental and physical deterioration of residents, which in turn requires more staff time. It is a vicious circle with tragic consequences for our seniors. We strongly advocate that the government introduce different subsidy levels for residents requiring different degrees of care regardless of the institution they reside in. We urge the government to introduce two levels of per diem rates for all long-term institutions: one for heavy-care (auxiliary) residents and another for light-care residents.

We have researched extensively the impact of funding on resident care and staffing levels. It is clear that many of the problems encountered by employees, especially the inadequate staffing levels, originate from insufficient funding. Under present regulations, all licensed nursing homes (private, non-profit and public) receive funding in the amount of $54.00 per resident per day for a semi-private room. Of this amount, $37.50 is paid by the Alberta Government and $16.50 is paid by the resident. On the basis of this funding, all nursing homes must provide 1.65 hours of nursing care per resident per day. In contrast, auxiliary hospitals, which like nursing homes provide long-term care primarily to the elderly, receive an average of $120.00 per day per resident, of which $16.50 per

day is paid by the resident. However, in addition to their per diem funding, publicly owned nursing homes and auxiliary hospitals also have all their building, furniture and fixture costs paid for by the Government.

We urge the Government to equalize funding to auxiliary hospitals and nursing homes on the basis of actual care given. We further urge that the minimum level of nursing hours required be increased drastically and that the admissions policies of nursing homes and auxiliary hospitals be merged. It is no longer good enough to assume that we have provided for the needs of our elderly when the premises are clean, airy, roomy, and warm. Is it not ironic that Canada spends $45,000 a year (approximately $120.00 a day) on housing one prisoner, yet Alberta spends less than 30 per cent of that amount on a senior disabled citizen in a nursing home?

We recommend:

14. that every nursing home be licensed for both heavy-care (auxiliary) residents and light-care residents;

15. that the per diem rates paid to all licensed nursing homes be as follows:

Heavy-Care (Auxiliary) Residents	$100.00 (including resident portion)
Light-Care Residents	$ 65.00 (including resident portion)

and that these rates be reviewed annually;

16. that the government develop a single long-term care institutional system.

DISPUTE RESOLUTION

When it comes to negotiations in the health care industry, Alberta's history is one of confrontation. Nursing homes and auxiliary hospitals have not been exempt from such disputes.

In the early 1980s, wage rates in all nursing homes were uniform. Today wage rates paid to nursing home employees in publicly owned (district) homes range from $2.00 to $2.50 per hour higher than in private and non-profit nursing homes. This gap reflects in part the fact that there is additional funding available for public (district) nursing homes. Nevertheless, much of the current wage disparity is the result of labour legislation (Bill 44) passed in 1983, which requires publicly owned nursing homes to rely on compulsory arbitration in the event of a labour negotiations dispute. The Government wanted to ensure that the sick and elderly would not become victims of confrontational labour-management relations. For some unknown reason, the members of the Legislative Assembly believed that the sick and elderly had to be protected while they were in public institutions but did not need similar protection when they were in privately owned institutions. Private and non-profit nursing home employees still have only the strike as a means to press their demands. Most nursing home employees are reluctant to walk off the job and thereby abandon residents who depend on them. It is obvious from the prevailing wage disparity between public and private homes that the strike weapon is an unacceptable method of dispute resolution for health care employees.

We firmly believe that compulsory binding arbitration is the only sensible way to resolve labour relations differences between labour and management in the health care industry. To allow withdrawal of services in institutions that care for the sick and infirm is irresponsible and inhumane. We urge the provincial government to eliminate this inconsistency.

We recommend:

17. that the government extend current legislation to ensure that private and voluntary nursing home labour disputes are resolved through compulsory binding arbitration.

CONCLUSION

We wish to say that all the nursing home employees who met with the Task Force displayed a high degree of dedication and concern for the well-being of the residents in their institutions. Almost all of them love their work; many give of their own time to the residents. But all stated that the pace of work is too hectic and that the care of the residents suffers as a result. Most of the people we talked with are working in nursing homes because they wish to give quality, loving care to those no longer able to care for themselves. Due to insufficient time, the work has become factory-like. Though still performed with care and compassion, the work is so regimented that there is no time to look after the emotional well-being of the residents.

Although some improvements can be made in a number of nursing homes across the province, nothing will change very much unless the Government is prepared to implement the recommendations made in this report and corresponding recommendations made by the Hyde Commission in 1982 and in the recently released report, "A Vision for Long-Term Care." The province must financially commit itself to the long-term care of our elderly to make it possible for them to be cared for in a way that preserves their human dignity, provides for their physical and emotional needs, and ensures that they do not become pawns in the political trade-off between private and public ownership.

As our society ages and, unfortunately, family units weaken, we must make a firm commitment to designing excellent support systems for the physical and emotional well-being of our seniors.

RECOMMENDATIONS

We recommend:

1. that every nursing home be required to provide a minimum of 2.75 hours nursing and personal care each day to each heavy-care (auxiliary) resident (p.13);

2. that every nursing home be required to provide a minimum of 2.0 hours nursing and personal care each day to each light-care resident (p.13);

3. that inspection of nursing homes be conducted unannounced and that inspectors interview employees from all shifts and from all departments, as well as residents, in confidence and in the absence of management (p.14);

4. that orientation and training of new staff in nursing homes be done by competent supervisory personnel (p.16);

5. that each nursing home be required to give a minimum of ten days orientation and training for new inexperienced staff before they are allowed to work alone and five days for new staff with a PCA Certificate (p.16);

6. that the Government require nursing aides to obtain a Personal Care Aide certificate, provided that existing employees receive enough leave time to follow the required courses, and provided that "grandfather" provisions are made available to those with three or more years experience (p.16);

7. that funds be set aside to replace staff attending in-service sessions, to pay in-service program participants who are unable to attend during scheduled work hours, and to improve the quality and effectiveness of the in-service programs themselves (p.16);

8. that activity programs for heavy-care residents be implemented on an individualized (one-on-one) basis (p.17);

9. that residents of nursing homes, when capable, be allowed to determine their own hours of getting up and going to bed, within reasonable time frames (p.18);

10. that every newly constructed nursing home shall eliminate all wards accommodating more than two residents (p.20);

11. that every nursing home shall, within a reasonable time span, provide a separate washroom for each room, accessible by wheelchair (p.20);

12. that every nursing home be required to make dining room service available for its residents, and that residents be allowed to select their meals from a variety of foods at a time of their own choosing within normally set hours (p.23);

13. that every nursing home have on its residents' council an informed individual from the community to serve as a liaison between nursing home management and the residents, and that management personnel not serve on residents' councils but be available as resource persons when so requested (p.24);

14. that every nursing home be licensed for both heavy-care (auxiliary) residents and light-care residents (p.29);

15. that the per diem rates paid to all licensed nursing homes be as follows:

Heavy-Care (Auxiliary) Residents	$100.00 (including resident portion)
Light-Care Residents	$ 65.00 (including resident portion)

and that these rates be reviewed annually (p.29);

16. that the government develop a single long-term care institutional system (p.29);

17. that the government extend current legislation to ensure private and non-profit nursing home labour disputes are resolved through compulsory binding arbitration (p.30).